

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County Bole

Registration District No. 210

Township Jefferson

Primary Registration District No. 5014

City St. Marys (No. 1)

File No. 26816

Registered No. 205

St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Osage City, Mo.
(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 3-1917

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>10</u>	<u>10</u>	<u>24</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

10. NAME OF FATHER Jno. L. Keeffe

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) N. Y.

12. MAIDEN NAME OF MOTHER Effie Warden

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Paas. Mo.

14. INFORMANT (Address) Jno. L. Keeffe Osage City, Mo.

15. FILED 9-7-28 W. B. Clifford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 27-1928

17. I HEREBY CERTIFY That I attended deceased from Aug 26, 1928, to Aug 27, 1928 that I last saw him alive on Aug 27, 1928, and that death occurred, on the date stated above, at 4 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia
2 to 3 (duration) yrs. mos. ds.
CONTRIBUTORY Injury & Amp. femoral (SECONDARY)
to wrist (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. Osage City

DID AN OPERATION PRECEDE DEATH. no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS. Urinal
(Signed) na clear M. D.
8/28.1928 (Address) Just a moment

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Paas. Mo. Aug. 29, 1928

20. UNDERTAKER ADDRESS
L. P. Heinrichs J. B. Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1928

State of

PHYSICIAN

License

Number

Expiration Date

1954

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Laclede Registration District No. 213 File No. _____
 Township _____ Primary Registration District No. 2014 Registered No. 205
 City St. Louis (No. _____) St. _____ Ward _____

2. FULL NAME Elizabeth Keese
 (a) Residence. No. _____ (Usual place of abode) Osage City, Mo. (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(For the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 3, 1917

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
10 10 24

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at school
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Genoa, Pa

10. NAME OF FATHER Joe Keese

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Pa

12. MAIDEN NAME OF MOTHER Effie Kaden

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Pa

14. INFORMANT Joe Keese
 (Address) Osage City, Mo

15. FILED 9-6-25 L. S. Sedgwick
 REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 27 1928
 17. I HEREBY CERTIFY That I attended deceased from Aug 26, 1928, to Aug 27, 1928, that I last saw her on Aug 27, 1928 and that death occurred, on the date stated above, at 7 p. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Tetanus
Shipped on nail

CONTRIBUTORY (SECONDARY) Injury 8 days previous to attack
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, Osage City
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) W. G. Clark, M. D.
 (Address) Jefferson City, Mo

*State the DISEASE CAUSING DEATH, if so deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Pa DATE OF BURIAL Aug 29 1928

20. UNDERTAKER C. P. Heinrich ADDRESS Pa

REGISTRATION should be carefully supplied. AGE should be stated EXACTLY. PH ANS should state CAUSE in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-24816